ATTACHMENT 6
Prior Authorization Request Form (PA/RF) Completion Instructions for personal care services

(For prior authorizations submitted after HIPAA implementation)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with all applicable service-specific attachments including the Wisconsin Medicaid Home Care Assessment Form or Update Form and a copy of the physician's orders, by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Note: Wisconsin Medicaid accepts PA requests with a maximum of 12 details per PA number. The Wisconsin Medicaid PA/RF has space for five items. If a provider's PA request requires more than five items to be listed, the provider may continue the PA request on a second and third PA/RF. When submitting a PA request with multiple pages, indicate the page number and total number of pages for the PA/RF in the upper right hand corner (e.g., "page 1 of 2" and "page 2 of 2"). On the form(s) used for page 2 and, if appropriate, page 3, cross out the seven-digit PA number and write the PA number from the first form. Refer to instructions for Elements 16 and 22 for more information.

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type
Enter processing type "120" for personal care services by a dually certified home health/personal care agency and "121" for services by a personal care-only agency. The processing type is a three-digit code used to identify a category of service requested. Prior authorization requests will be returned without adjudication if no processing type is indicated.

Element 4 — Billing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1.

SECTION II — RECIPIENT INFORMATION

Element 5 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 6 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 7 — Address — Recipient
Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 8 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 9 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 10 — Diagnosis — Primary Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Start Date — SOI (not required)

Element 12 — First Date of Treatment — SOI (not required)

Element 13 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 14 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested.

Element 15 — Performing Provider Number (not required)

Element 16 — Procedure Code
Enter the appropriate procedure code for each service/procedure requested.

Note: If the provider needs additional spaces for Elements 16-21 for the PA request, the provider may complete additional PA/RF(s). The provider needs to cross out the preprinted PA number on the additional PA/RFs and write in the preprinted PA number from the first PA/RF. The PA/RFs should be identified, for example, as "page 1 of 2" and "page 2 of 2."

Element 17 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed in Attachment 1.

Element 18 — POS
Enter the appropriate place of service (POS) code designating where the requested service/procedure would be provided/performed/dispensed.

POS	Description
12	Home
34	Hospice

Element 19 — Description of Service
Enter a written description corresponding to the HealthCare Common Procedure Coding System procedure code for each service/procedure/item requested.

When requesting personal care services, indicate the number of units per week multiplied by the total number of weeks being requested. The total number of units requested on the PA/RF must be equivalent to the total number of hours ordered by the physician (4 units = 1 hour). If requesting travel time, enter this as a separate item using procedure code T1019 and modifier U3. Instructions for the physician's orders and the Wisconsin Medicaid Home Care Assessment Form are *not* changing.

If sharing a case with another provider, enter "shared case with (name of other provider)" and include a statement that the total number of units of all providers will not exceed the combined and total number of units ordered on the plan of care.

Element 20 — QR
Enter the appropriate quantity requested in units for the procedure code listed. To calculate total quantity requested, multiply the number of hours per week by the number of units per hour (4 units = 1 hour). Multiply that number by the number of weeks requested (e.g., hours/week x 4 units/hour x number of weeks). For example, 14 hours/week x 4 units/hour x 53 weeks = 2968 units.

Element 21 — Charge
Enter your usual and customary charge for each procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each procedure requested. Enter that total amount in this element.

Note: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 22 — Total Charge
Enter the anticipated total charge for this request. If the provider completed a multiple-page PA/RF, the total charges should be indicated on Element 22 of the last page of the PA/RF. On the preceding pages, Element 22 should refer to the last page (for example, "SEE PAGE TWO.")

Element 23 — Signature — Requesting Provider
The original signature of the provider requesting this service/procedure must appear in this element.

Element 24 — Date Signed

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.